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St. Bartholomew's Hospital Journal,

MARCH, 1903.

"Æquam memento rebus in arduis
Servare mentem."—*Horace,* Book ii, Ode iii.

Presentation and Dinner to Mr. Butlin.

ON December 31st Mr. Butlin was entertained at dinner at the Café Royal by his old house surgeons. It is rather more than ten years since Mr. Butlin became full surgeon to the hospital, and every one of those who served under him as house surgeon is still actively engaged in the practice of his profession. It was, however, unfortunately impossible to assemble an undivided family; five were resident abroad, and of the others, three were for various reasons unable to be present. The dinner was quite an informal one, but his pupils wished to present Mr. Butlin with some small token which might serve to remind him, and possibly his son after him, of the affectionate regard in which he was held by those who were most intimately associated with him in his work as a surgeon and teacher at our Hospital. The present took the form of an embossed silver salver, the work of Gilbert Marks.

In making the presentation, Dr. Williamson (who was in the chair) spoke of the very real loss which both the Hospital and the School had sustained through the retirement of Mr. Butlin, and said that his duty was not to pronounce a eulogy upon the surgeon, that would be done by other and more eloquent lips, but to speak rather of the teacher they had so well learned to respect, and of the friend they had all learned to love; that Mr. Butlin was leaving them whilst still in the noonday of his life's work, and that though the loss was great to Bart.'s, they all knew that there lay before him still wider spheres of usefulness; but though leaving them early he had bequeathed that which was the greatest gift a teacher could possibly bestow upon his pupils, the memory of an honourable and upright character, of a fine scorn for the little meannesses and petty tricks which have sometimes tarnished the fair fame of our profession, and a high ideal of conduct. In reply Mr. Butlin said:

"Although I have had considerable experience of after-dinner speeches, I do not know when I have felt it so difficult to speak as I do to-night. Thinking over what I would say, I felt sure you would not want a long speech, or an elaborate speech, or any attempt at oratory; and I finally came to the conclusion that I would speak very shortly, and would do little more than thank you for entertaining me at dinner and for your silver gift. Yet thanks expressed in words do not in the least tell what I feel to-night. It is not only that you invited me to dine with you, and that you have given me a peculiarly handsome salver, which is beautiful as a work of art, and with which I have only one fault to find—that you have

expended too much upon it,—but that you might easily have escaped both the dinner and the gift on the ground that I have left the Hospital so much earlier than I need have done. Yet you have chosen to do it, and I feel this the more because I think you would not have done it had you not liked me personally.

"I hope that by-and-by this salver will be handed down as a prized possession to my son, although I know that he will never be able to appreciate what it meant to Mrs. Butlin and myself. For it is not merely that it is presented to me by a certain number of my old pupils, but that among those old pupils there is scarcely one who is not distinguished above the average man. I will not venture to boast that my house surgeons have been the pick of the School for the last ten years, although they seem to me to have been so; nor can I refer to such a record of your achievements as my colleague Mr. Willett was able to do not long ago. Indeed, it would not be reasonable to expect me to be able to do so, for it is scarcely more than ten years since I was appointed full surgeon to the Hospital. But I can say that there is scarcely one of my house surgeons who has not taken either a distinguished degree or a high qualification; that many of them have gained honours either in the School or when they took their degrees, and even in these last few days two of them have brought honour to the Hospital and School by their success at the University of London (Rowe and Scott). In addition several of them have held or are now holding teaching appointments in our own or some other hospital school, and I look forward to seeing some of my past house surgeons on the permanent staff of St. Bartholomew's Hospital. In any case I am quite sure that there is not one of my house surgeons who is not likely to rise to the highest position which is open to him in the place in which he ultimately settles.

"I wish it had been possible for every one of my past house surgeons to have been present at this dinner; I should so much like to have seen them all together; but it could not be. Thomas, Maxwell, Butler, Clark, and Douglas are all in distant parts of the world. The career of each one will be watched with the greatest interest, and not altogether unselfishly, for I have always held that the success of the pupils redounds largely to the credit of the master, and ought to afford him the liveliest pleasure. I do not know whether it will be possible, but I should like to collect all my old house surgeons at a similar dinner to this five or ten years hence, if we are all alive; but they as my guests, not I as theirs; and I shall try to do so.

Until then I wish you good-bye and God-speed, and I hope that those of you who leave London and settle far from here will write me from time to time, as Maxwell has done, in order that I may keep in touch with you. And once more I thank you for this most pleasant dinner and for your present.

On Meningitis.

By HUGH THURSFIELD, M.D., M.R.C.P.

(*A Paper read before the Abernethian Society.*)

MR. PRESIDENT AND GENTLEMEN,—I do not know whether other men have experienced the same difficulties as myself in grasping the nature of the group of diseases called meningitis, but I hope I may at least assume that this part of medicine is not the easiest, and that some consideration of the difficulties will not be without interest.

First, then, to define the subject. I do not propose to speak of the rarer forms of meningitis,—that pachymeningitis, for instance, which is seldom met with outside lunatic asylums, which need trouble none of us who do not propose to enter such abodes. The inflammations I am talking of are those of the pia-arachnoid of the brain, and incidentally of the spinal cord, the common types which we meet with. The classification of these used to be a torture to the student; there was, in fact, only the tuberculous form which stood out distinctly from the others; and other forms were often lumped together as simple meningitis; and it was believed that there was a special syphilitic meningitis independently of the gummatous form. Now bacteriology has sufficiently advanced to be able to assert that, apart from epidemic meningitis or cerebro-spinal fever, and the closely allied disease posterior basic meningitis, primary affection of the meninges is a very rare disease. There are indeed rare cases of primary pneumococcus meningitis, and possibly other forms may yet be isolated, but for the present, at any rate, we can limit our list of primary forms to these three. Secondary forms include that due to the tubercle bacillus, those caused by pyogenic organisms, including the pneumococcus again; and those met with in various acute fevers, such as typhoid. To summarise the pathological aspect, the chief forms which are met with clinically are those due to (i) the tubercle bacillus; (ii) the *Diplococcus intra-cellularis meningitidis;* (iii) the pneumococcus; (iv) the strepto- and staphylococcus. All other varieties, whatever charm they may possess to the earnest bacteriologist, at present at least do not concern the clinician. There have been, for example, certain cases of meningitis recorded from which pure cultures of the *Bacillus typhosus* have been isolated; these, however, are so rare as to be curiosities. Now it may be said that meningitis is altogether pathological in its interest; that it is an interesting feature in the landscape of the post-mortem room; but that in the wards, once diagnosed, it ceases to interest because it is inevitably fatal. But, firstly, it is by no means inevitably fatal; certain forms have a considerable percentage of recoveries, sometimes with, sometimes without sequelæ of a more or

less interesting character; and again, there lie immense possibilities in the words "once diagnosed." The difficulties of diagnosis are so great, and error is so common, that it is, I believe, safe to say that only a comparatively small number of the cases diagnosed as meningitis are in reality examples of that disease.

In the first place you must diagnose meningitis correctly; before you attempt to say what form is present you must be in a position to be sure that some one of the forms is present. Now the symptoms which characterise meningitis are briefly these:—fever more or less pronounced, with its accompaniments of malaise, increased frequency of the pulse, and loss of appetite; headache; vomiting or convulsions; and some sign of affection of the cerebral substance, such as a squint, a slight palsy, or only general irritability. Numerous cases of meningitis die without any more definite signs of intra-cranial disease than are comprised in this list, and it will be obvious at once that in children at any rate numerous diseases other than meningitis can give you all of them. Hence we find that meningitis is often diagnosed in pneumonia, in typhoid, in acute diarrhœa, in acute tuberculosis, and in other affections where it does not really exist. Practically, however, in children the difficulties usually met with are only three in number, but those three are very formidable: (i) are the signs those of meningitis or an acute infectious disease which will presently develop itself? (ii) are the signs those of meningitis or of one of those acute cerebral inflammations which terminate in infantile hemiplegia—for instance, an encephalitis? (iii) is it a case of meningitis, septic or tuberculous, or merely one of middle ear disease? So it becomes necessary to examine in greater detail the symptoms which one may expect to find in a case of meningitis. First, as to the *fever*, let me make a dogmatic statement, which, like all such assertions, must not be taken to be without exception. It is this: a fever which surpasses 103° is not due to tuberculous meningitis. I believe that it will be found that this rule is a very valuable aid, for it at once excludes nearly all the cases of pneumonia and typhoid fever which present us with the problem; but it does not of course afford any assistance in the exclusion of other forms of meningitis; the tuberculous form, however, is much the most common. As to the other symptoms met with in the early stages of the disease, the severe headache, the vomiting, and the irritability, they are common in nearly all acute illnesses in children. There is only one other of the prodromal signs which need to be mentioned, that is *constipation*, a common symptom, it is true, but when in a case which presents meningeal signs you have a history of a week's obstinate constipation it will be found that the disease is often tuberculous meningitis. I cannot explain the cause, but the fact remains that unusual constipation often precedes the definite appearance of the disease. Passing on to the irritative stage of the disease, the first thing noticeable is the relation between the *headache and the delirium*. In acute fevers, such as pneumonia and typhoid, the headache, as a rule, disappears with the onset of delirium; in meningitis, on the other hand, the two progress side by side, and in the stage of delirium the pain of the headache sometimes extorts from the patient that cry so characteristic of the disease which is called the "*hydrocephalic cry*." It is not, so far as my own limited experience goes, a very frequent occurrence, but any one who has once heard it can never a second time mistake it for any other noise made by a child; it is, I believe, absolutely distinctive. Coming to the local cerebral phenomena, the most striking is the *retraction of the head*. This is a sign closely allied with meningitis of the posterior portion of the brain, and that being so is especially well marked in cases of posterior basic meningitis and cerebro-spinal fever, where the exudation is most marked in that situation. It is also present, but to a much less extent, in tuberculous cases, these rarely showing the extreme degree seen in the other form. In cases of pneumococcic and pyogenic meningitis, in which the inflammation is not so much confined to the base of the brain, the symptom is much less usual and much less marked. Moreover retraction of the head, even when marked, does not necessarily imply meningitis. I have seen cases of acute fevers, of acute diarrhœa, of chronic wasting, and of simple rickets, in all of which the retraction of the head was a marked feature. The cause of the retraction in any case is obscure; possibly it may be connected with irritation of the cervical nerve-roots.

Rigidity of the muscles is a common phenomenon, and that special form of it which is known as Kernig's sign is a very valuable aid in the diagnosis of meningitis. It is not, of course, pathognomonic, though that claim has been advanced, but it is met with far more frequently in cases of meningitis than in any other disorder. It consists, as you know, in a hypertonus of the flexor muscles of the thigh, rendering it impossible in the sitting or lying position to place the patient's straightened limb at right angles to the body.

Strabismus is a constant symptom of meningitis of the base, and usually a fairly early one; often associated with *nystagmus* and a *sluggish reaction of the pupils* to light. The association of these last two strengthens the value of the first; alone it is often seen in non-meningeal complaints. One of the characteristics of this meningeal squint is the dissociation of the conjugate movements of the eyes, each eyeball moving on its own axis quite independently of its fellow, a feature not usually observed in cerebral squints due to other causes,—for instance, cerebral tumours.

The *ophthalmoscope* again affords valuable information. Apart from choroidal tubercle, which, of course, establishes the diagnosis and enables a definite prognosis, nearly all

cases of tuberculous meningitis show more or less swelling of the disc, sometimes slight, more often pronounced. Posterior basic meningitis, on the other hand, though occasionally giving rise to well-marked papillitis, much more frequently causes an unusual opaque grey appearance of the disc, quite unlike the normal colour. It is not atrophy, for though, as you know, such patients are often quite blind, yet in those that recover from the disease the sight is often completely restored. In pyogenic and pneumococcic meningitis there is, as a rule, no change in the fundus oculi.

While on the subject of the eye symptoms I should like to mention an important point in the diagnosis between tuberculous and post-basic meningitis. In the first, as you know, the patient almost invariably keeps his eyes tight shut, and resents any light brought near to him. In the other disease, on the contrary, the upper eyelid is often considerably retracted, so as to show the sclerotic above the cornea, giving to the face a characteristic staring appearance.

Convulsions are common in pneumococcic and pyogenic meningitis, rare in the early stages of the tuberculous and posterior basic forms. Occasionally, however, it happens that tuberculous meningitis sets in with a convulsion, and in these cases generally several days elapse before the diagnosis is established; the "fit" is supposed to be an infantile convulsion, due to improper food, or the herald of some infectious fever, and it is only when further definite meningeal symptoms appear that the real character of the illness is recognised. One such case I remember very well: a child admitted with convulsions, which ceased in a short time; during the next week the child had a slight fever, but was otherwise fairly well; it then began to pass blood in its motions, and typhoid was suspected. However, about the end of a fortnight choroidal tubercles were detected, and two days later it presented the typical appearance of meningitis, and died in the fourth week. The bleeding had come from tuberculous ulcers of the small intestine.

Paralyses, apart from those of the eyeball, are not common in the early stages; where they do occur they are usually partial and slight, but of the greatest possible value. Facial palsy, however, is much more commonly due to middle ear disease than to intra-cranial mischief. In the paralytic stage of meningitis there is, as a rule, no difficulty in diagnosis of the disease, though it may be difficult to diagnose the particular form present. The stupor or coma, the fixed and dilated pupils, the retraction of the abdomen, the squint and cerebral breathing combine to render the diagnosis certain.

Now, after this review of the common symptoms, can we attack our three practical problems with any greater assurance? In the first pneumonia and typhoid fever are the two chief causes of trouble. I may say at once that I believe there are cases of pneumonia which it is impossible to say are not cases of meningitis until several days have elapsed; but, as I have pointed out, the temperature chart offers valuable indications, being usually below 103° in tuberculous meningitis, and often 104° or 105° in an acute pneumonia. Secondly, the history of a week's ailing before the attack is unusual in pneumonia, common in meningitis. Again, the relation of the headache and the delirium is of value: the pneumonia patient, while wildly delirious, does not often have the severe headache of the meningitis case; and though he often has strabismus, this is not usually associated with marked sluggishness of the pupils. But it is to the whole clinical picture that we must trust rather than to selected details, and while doing so constantly remember that pneumonia is far more often diagnosed as meningitis than *vice versâ*, and hence in a doubtful case give the verdict for the less fatal disease. In the case of typhoid fever we have more definite guides. If we cannot obtain Widal's serum reaction we can count the leucocytes of the blood. As you know, in typhoid these are diminished, whereas in all forms of meningitis, and notably in the pyogenic and pneumococcic forms, they are considerably increased; probably there is no diagnostic value in the blood-count as between tuberculous and post-basic forms. It seems to be an appropriate place here to speak of the value of *lumbar puncture* as a means of diagnosis. It is in children a simple operation, and without any danger except that of sepsis, which ought to be in these days a negligible risk. There seems to be no doubt that in the majority of cases it is possible to diagnose meningitis and differentiate its forms with greater accuracy by this than by any other means, and to my mind it is a measure which should be undertaken just as often and as readily as a simple puncture of the pleural cavity. It is, I believe, absolutely useless as a therapeutic measure, save that in certain cases it does seem to relieve the pain in the head and the vomiting. The chief value of the method lies, of course, in the ease with which the micro-organism infecting the meninges is obtained in pure cultivation: if no bacteria are found the case is probably tuberculous. A further distinction has lately been established: in a meningitis caused by the pyogenic cocci the pneumococcus or the meningococcus polymorphonuclear cells are the chief constituents of the sediment of the spinal fluid, whereas in tuberculous cases lymphocytes far outnumber other forms.

Secondly, the diagnosis between an acute encephalitis and meningitis forms a difficulty; here, as a rule, a few days suffice to clear up the difficulty, but in at least two cases the diagnosis of meningitis was confidently made at first. Head retraction, rigidity of muscles, a squint, fever, and general irritability, together with a loss of power in the limbs and a good deal of muscular tremor, made confusion almost inevitable. I cannot give any distinguishing features between these cases and tuberculous meningitis; looking

back at the instances I have seen, the only difference appears to be in the abrupt onset of the symptoms, as contrasted with the slower and more gradual onset of meningitis, though this does not by any means always hold good.

Lastly, we come to the most practical difficulty of all, the distinction between middle ear disease and meningitis, and, it may be added, abscess. It seems to be impossible to be always sure of the diagnosis, nevertheless there are certain symptoms which point to one or the other. The meningitis may be septic or may be tuberculous—I am assuming of course that there is no doubt whatever about the existence of the ear trouble;—if it is a septic meningitis complicating the ear disease one may expect a more or less sudden rise in the temperature, accompanied by severe headache, irritability of a pronounced degree, and the development of local palsies, facial and ocular, and the presence of Kernig's sign. Convulsions and rigors also not infrequently occur. If, on the other hand, tuberculous meningitis be present, there is usually a longer interval in the development of the signs, the temperature is not so high, and the local palsies usually absent; facial palsy in the tuberculous meningitis is uncommon, and if it occurs in such a case as we are now considering it is most probably the result of a septic invasion of the membranes; if due to the involvement of the facial nerve itself in the middle ear, it is of course of the peripheral type, but that does not help us in the present case, for the only difference in a paralysis due to a lesion of the facial nerve between its exit from the pons and the Fallopian aqueduct, from that due to a lesion in the middle ear, is the fact that in the first taste is unaffected, whereas in the latter the chorda tympani is involved. This difference of course, in a child in a more or less comatose condition, cannot be discovered. The only help we can get is to attempt to determine at what period the facial palsy was first noticed, whether before or after the onset of the acute symptoms, and whether it is increasing in degree. A slight facial weakness, developing rapidly to a definite palsy, is strong evidence in favour of meningitis. Retraction of the head, irregular respiration, and a slow irregular pulse are also signs of meningitis rather than of middle ear disease; but again we must depend rather on the association of a number of slight symptoms than on any single symptom.

Returning to our original outline, after we have diagnosed the existence of meningitis we must next endeavour to discover with what form we have to deal. I have already in the course of these somewhat scattered remarks mentioned some of the differences which seem to me to exist, but I may sum them up again in the form of a comparative statement. In septic and in most cases of pneumococcic meningitis it is possible to find some source from which the infection may have spread. Septic meningitis follows middle ear disease, erysipelas, disease or injury to the skull, or septic infection of any of the cranial cavities,—for instance, sepsis following the removal of adenoids, an orbital abscess, or a local necrosis in the bones of the nose and ethmoidal sinuses; or, again, it may result from some distant source of infection, an osteomyelitis, an acute arthritis, a portal pyæmia, a malignant endocarditis, or an appendicitis; and, most rare of all causes, it may complicate scarlet fever or typhoid, or terminate a chronic nephritis. The pneumococcic form most often follows broncho-pneumonia or empyema; a neglected or undiagnosed empyema being a frequent cause of the condition. In all these cases, whatever be the cause, the duration of the disease is short, the symptoms, as a rule, severe and unmistakable, and the diagnosis usually made without trouble; but in a certain proportion the symptoms of the primary disease so mask the signs of meningitis that the discovery is only made at the post-mortem examination. The signs to be looked for principally are the occurrence of rigors and convulsions, the rise of temperature, the irregularity of pulse and respiration, and the increasing drowsiness with local palsies. Even in these cases, however, meningitis is sometimes diagnosed where it does not exist. A child with an empyema, which had been drained, had a sudden convulsion followed by a marked internal squint and a semi-comatose condition, with a sudden cessation of all discharge from the pleural cavity. She was supposed to have meningitis, but as her condition on the third day was no worse, her pleural cavity was explored, and a large piece of a gauze drain was found inside. The removal of this was followed by a complete and rapid recovery, and the disappearance of the meningeal symptoms, though the squint remained for many days.

The difficulty and the importance of diagnosis, however, are not so great in these cases as in the tuberculous and posterior basic forms, for here the similarity of the symptoms is great and the prognosis very different; for whereas tuberculous meningitis is probably always fatal, posterior basic meningitis not infrequently recovers. "Tuberculous meningitis is always fatal" is a statement which has been made in all the text-books, but will probably have to be modified in the future, for there are now on record several cases in which with the presence of meningeal symptoms tubercle bacilli have been isolated from the cerebro-spinal fluid, and yet the patients have recovered. Still, generally speaking, there is no hope of recovery in the tuberculous form. If, then, one is able to diagnose posterior basic meningitis it is possible to assure relatives that there is a chance of complete recovery, an assurance which will be all the more welcome because to the lay mind meningitis means death. As a matter of fact the prognosis in posterior basic meningitis is unusually difficult to discuss, because, so far as I can discover, there is comparatively little known. It is certain, however, that below the age of two years recovery is very rare; above that age it is not uncommon. Personally I have seen one child under two, who was thought to have the disease, recover, but the

symptoms were by no means conclusive, and it is quite possible they were due merely to the marasmic condition. On the other hand, I have known of three cases above that age recover completely without apparently any sequelæ in the shape of headache or intellectual weakness. Unfortunately there is another side to that picture, recovery leaving the child "with wisdom at all entrances quite shut out"—blind, deaf, and dumb, and degenerating rapidly to an imbecile. Happily in a few more years now, aided by lumbar puncture, we shall know far more of the distribution, frequency, and course of this disease than hitherto. Dr. Still's demonstration of the organism, which is probably the same found by Weichselbaum, in epidemic cerebro-spinal fever, renders the problem much easier. Posterior basic meningitis often sets in abruptly with high fever, occasionally convulsions, sooner or later some retraction of the head, persistent vomiting, and rapid emaciation; in other instances the onset is more insidious, and especially in young infants is hardly noticed, until the bulging of the fontanelle or the marked head retraction calls attention to the condition, at which period the disease has often reached the quiescent stage, and the patients die rather of the mechanical sequelæ than of the poison itself. The first point of difference, then, from tuberculous meningitis is the abrupt onset of the illness, and in some cases the height and curve of the temperature. The second is the retraction of the head, which scarcely ever reaches in tuberculous meningitis the extreme degree which is found in the other form. The third is the extreme rapidity of the emaciation, as you have, no doubt, noticed the subjects of tuberculous meningitis often present a large amount of subcutaneous fat at the examination. In posterior basic meningitis, on the other hand, except in those rare cases which are of the fulminant type, there is usually the most marked wasting of the tissues. Other small differences are the presence of skin rashes, especially herpes, the comparative rarity of marked squints, with the staring appearance of the eyes already mentioned, the frequency of diarrhœa as opposed to constipation, and the slighter character of the mental and intellectual dulness. It is dangerous to lay down dogmatic rules for diagnosis, but I think it is possible to say that the presence of symptoms of meningitis in a child under two years of age, coming on abruptly, with persistent vomiting, a considerable fever, and retraction of the head, is best accounted for by an infection with the *Diplococcus intracellularis;* that the same symptoms in an older child must lead you to a consideration of all the smaller points I have mentioned, and unless the balance of these is against it the probability is strongly in favour of the diplococcus again.

Thirdly, that in a certain number of cases the diagnosis will be very doubtful in the first week, and very clear in the second. And lastly, that there is a small residue which remains uncertain until you can examine the spinal fluid by lumbar puncture, or until you see the typical lesions at the autopsy.

In conclusion, I must apologise for the desultory nature of these remarks, which probably contain very little that is new to you. I have tried to make them dogmatic, because it appeared to me that discussion would be best aroused by confident statements. I venture to suggest that those who follow me should especially direct their attention to (1) the diagnosis of meningitis, especially in cases of middle ear disease; (2) the differentiation of the various forms; and (3) the question of prognosis.

On Puerperal Fever.

By R. C. ELMSLIE, M.B., B.S.

(*A Paper read before the Abernethian Society.*)

IN the course of its history a disease usually passes through three stages of definition. First it is defined by a description of its symptoms and clinical course, later by an account of its pathological anatomy, and finally by the discovery of its actual cause. Only when the third stage has been reached is the disease on a sound footing, and only then can rational treatment be adopted.

Puerperal fever for long lacked a definition, and hence we find that during the eighteenth century, when it first aroused the interest of medical men, different writers adopted different definitions, and thereby frequently excluded from their subject-matter diseases which were essentially puerperal fever. Briefly, at the present day we may adopt the definition that puerperal fever is the result of infection of the genital passages with pathogenic organisms at or about the time of labour. A physiological traumatic condition is essentially associated with delivery. In extent this involves the whole body of the uterus, from which the superficial layer (decidua) has been shed, thus laying open the lymphatic vessels, and over the placental site the various sinuses also. It involves also the cervix and vagina, especially the vaginal orifice at its posterior part, and the os uteri, both of which may be said to be invariably lacerated during first labours. To this traumatic condition we must remember to add that the edges of these wounds are frequently much injured by bruising, and specially that there is often retained in the uterus a portion of placenta or membranes, which, being so much dead tissue, forms an admirable nidus for the lodgment and growth of organisms.

Here, then, we have the essential elements in puerperal fever, viz. a septic infection of a wound in a situation where

the process cannot be seen, and whence the purulent discharges are not able to flow freely. With regard to the nature of the organisms concerned, they are many and various, streptococci, staphylococci, the *Bacillus coli communis*, and gonococci being the chief. In the worst cases streptococci are by far the commonest organisms, though others, not excepting the gonococcus, may produce fatal results.

The onset is usually within five days of delivery; the third day is the commonest for severe cases, though the fourth day is almost equally common in cases of less virulence of infection. The initial rise of temperature is often sudden, though sometimes gradual. It is stated that the sudden rise is more likely to take place in cases of virulent infection which are likely to prove fatal, the slow rise in cases of less virulent infection with retention of placenta or membranes. This sounds reasonable, but I do not think it is of much value; certainly in many cases of retention of placenta the temperature may rise rapidly to 104° or more, and equally certainly many of these cases recover if properly treated; whereas cases in which the rise is slow are apt to be made worse by deferring treatment on account of the slight symptoms. There is often an initial rigor; this, when present, is important evidence of septic infection, but it may often be absent, and unless repeated on subsequent days is of no value as an indication of the degree of virulence of infection. The pulse-rate is increased proportionately with the temperature; if it continues to increase in frequency this is always a bad prognostic sign. The skin is hot and flushed, and usually very moist, the sweating not uncommonly causing a miliary rash.

The most important diagnostic sign is that the uterus is larger than it should be, and tender. This has been recognised since the time of Hippocrates, and is an indication of the constant presence of local disease in puerperal fever, though, as we shall see, it was denied by the school of obstetricians, who considered the fever to be a specific inflammatory disease with no local pelvic lesion.

Of other symptoms I shall refer to only one, namely, the condition of the lochia. It is generally stated that the lochia are suppressed, and this statement has appeared in most books from the time of the ancients downwards. Now this may be true in those cases of septicæmia due to infection with virulent micro-organisms which occurred in the epidemics, and in other cases late in the disease But at the onset of the commoner cases of puerperal sepsis the lochia are more usually unaltered. Sometimes they become offensive, sometimes they have a peculiar acrid smell; in the few cases where they are diminished I think it most probable that it is obstruction to their flow that causes the septic absorption.

The septic process may spread from the uterine cavity in several ways:

1. In the case of infection with a virulent organism there may ensue an acute blood infection and death, with no further signs than the septic condition of the endometrium. This form is rare.

2. Sepsis may spread along the Fallopian tube, resulting in pyosalpinx, perimetritis, or general peritonitis.

3. Sepsis may spread by the lymphatics of the uterine wall to the peritoneum or to the pancreatic tissue, resulting in perimetritis, general peritonitis, or parametritis. This form is said to be the commonest.

4. Sepsis may spread by septic thrombosis of the uterine and ovarian veins, causing venous pyæmia. This form and the acute septicæmic form are the only varieties which are fatal without the supervention of peritonitis.

The variety of the lesions is well shown in ten fatal cases occurring in this Hospital during two years.

In three cases there was general peritonitis, in three local peritonitis, in one an abscess in the ovary, in one an abscess in the broad ligament, in one a pyosalpinx, in two there was thrombosis of an ovarian vein with pus in the vein, and one was a case of acute streptococcal septicæmia.

With regard to the nature of puerperal fever, down to the latter half of the eighteenth century the prevalent idea was that the fevers of the puerperium were due to obstruction of the flow of lochia or of the flow of milk. In fact, the subject was in the stage when the disease was defined by an enumeration of its symptoms, and one of these was arbitrarily selected as the cause.

Smellie, in his treatise on midwifery published in 1752, does not use the name puerperal fever, which was, however, first coined by Strother in 1718, and moreover he treats the subject of fevers scantily, and adopts the two causes mentioned above.

In 1760 occurred the first epidemic in England, and this was followed shortly by others, which recurred with terrible frequency chiefly in the lying-in hospitals, but also apart from them. These epidemics were doubtless the chief cause of the increased interest in the disease which was shown during the period from 1770 on. In many of them the infection assumed a very constant course, the lesion produced being general peritonitis. This fact, when dissections came to be made on the fatal cases, gave at first a false idea of uniformity to the disease, and led to the theory proposed by Dr. Hulme that "the puerperal fever" was a specific disease, and had no connection with the milder fevers of the puerperium which Hulme called miliary fever, milk fever, and inflammation of the uterus.

Dr. Hulme's account of the symptoms of the disease and the pathological appearances constitute an excellent picture of the results of general peritonitis; he found, as a rule, no local disease in uterus or pelvis, and his observations led him to the conclusion that the primary cause of the disease was pressure of the gravid uterus on the stomach and intestines, which, by a disturbance of their blood-supply, tended to start an inflammation. He

appears to have completely forgotten the contagious nature of the disease in propounding this theory.

Dr. Leake, in the same year (1772), published similar observations and drew similar conclusions, but in two instances he noticed local disease in the uterus, but ignored it as of no importance. The appearance that we now know as peritonitis was considered so characteristic of puerperal fever at this time that John Hunter, on finding this appearance in the body of a man, called the attention of those around to the fact that the man had died of "puerperal fever."

In 1791 Dr. Charles White called attention to the similarity of this disease to fever due to absorption from an abscess. He concluded that puerperal fever was due to absorption either from the bowel or from the uterus, and moreover he pointed out that there was often decomposing decidua to be found in the uterus in fatal cases. Dr. Kirkland previously, in 1774, and Dr. Clarke later, in 1793, came to similar conclusions. The latter's experiences are specially instructive, as he appears to have met with a far greater variety of pathological lesions than had others up to that time, and he includes in his account many of the forms of the disease which have been mentioned above. Two points of Dr. Clarke's teaching were of special importance.

1. He describes a class of fever as "the affection of the uterus and of the system arising from portions of the placenta left in the uterus," and mentions, under treatment of it, attempts to pick away the retained placenta with the finger, and injections of bark into the vagina and uterus.

2. He clearly recognised the importance of infection and contagion. By closing, cleaning, and whitewashing the Dublin Lying-in Hospital whenever a case of fever occurred he succeeded in preventing epidemics. His trouble and expense incurred by this remind one of the experiences of the City of London Lying-in Hospital nearly a century later.

The work of these physicians had resulted in a knowledge of the pathology of puerperal fever, and had suggested to some at least its true cause. Unfortunately the other theory, that of Hulme, maintained its ground, and was, in fact, accepted by the majority of obstetricians, with the result that no progress in the knowledge of the nature of the disease was made for about fifty years. The theory that puerperal fever was due to the decomposition of animal matter in the genital passages was again advanced by Semelweiss in 1847, this time as the sole cause of the disease. The decomposing matter was thought to be either developed in the uterus itself (autogenetic), or introduced from without (heterogenetic), but its nature was not understood, and it was only explained some thirty years later, when the discoveries of the relation of micro-organisms to disease paved the way to the true rational explanation of the puerperal fevers.

At the present day the importance of micro-organisms as the cause of puerperal fever is continually and insistently impressed on all. I cannot but think that the second element in the causation, namely, retention in the uterus of placenta or membranes, is being too much neglected. We may recognise two main types of puerperal fever. First, a rapidly fatal type, which may be an acute septicæmia, or more often shows, post mortem, general peritonitis. This is the type of the old epidemics, and of occasional cases apart from them. Second, a more slowly fatal type, where sepsis has spread from the uterus by the Fallopian tubes, or by the lymphatics, or by the veins, death resulting from peritonitis or pyæmia. This is the commoner type at the present day.

The existence of two types and of intermediate grades between them is easily explicable by a consideration of the micro-organisms causing them. We well know that organisms, when living on a suitable soil, increase their virulence considerably, and that the same organism—for example, the *Streptococcus pyogenes*—may cause infection of very varying intensity, according to its virulence. Marmorek, for example, found that the virulence of a streptococcus could be enormously increased by growing it alternately (*a*) on blood-agar and (*b*) in the body of a rabbit. Again, he found that the same species of streptococcus may produce at one time a passing local redness, at another a spreading erysipelatous condition, at another a local suppuration, or at another a general septicæmia.

It is easy, therefore, to see that the conditions in a lying-in ward in which a puerperal fever epidemic started were just those in which the organism would have its virulence increased by passage from woman to woman, and it is a well-recognised fact that infection with streptococci from a fatal case of peritonitis, the common lesion in these epidemics, is a very virulent infection. Now these severe cases are not as frequent at the present day, and those which occur are to be explained by infection from some virulent stock of streptococci, carried perhaps from some case of erysipelas or cellulitis. The ordinary streptococci, which occur in the air, in the skin, and, according to some, in the normal vaginal secretion, are not thus virulent, they cannot gain a direct entrance into the body by cuts and cracks; but give them some dead tissue on which to grow, and let there be perhaps some obstruction to the escape of the resulting pus, and they will increase so in numbers and in virulence that they will soon overpower their leucocytic or chemical antagonists, and spread into the tissues of the body. The uterine cavity, with in it some placental remains, thus offers to these streptococci an admirable resting-place, where they may gather strength and numbers for their attack on the deeper tissues.

There has now been a clear understanding of the importance of both the causative factors of puerperal fever for more than twenty years; this period should be sufficient to reduce considerably the prevalence and mortality of the

disease, but, unfortunately, this has occurred to only a slight extent if at all, and the prevalence and fatality of the disease appear to be as high as ever, a very disappointing result after the work of a hundred years at the elucidation of the nature of the disease.

No doubt puerperal fever has always been prevalent, but its modern history commences with the occurrence of the first epidemics. The earliest of these occurred at the Hôtel Dieu in Paris in 1746, and was followed by the first in England, at the British Lying-in Hospital, in 1760. From this time on epidemics were frequent all over England, in Dublin, and in Paris, and though they occurred to some extent in private practice, they were far more prevalent in lying-in hospitals.

What was the cause of the appearance of these epidemics? Probably two causes contributed to it. In the first place, up to the middle of the seventeenth century the practice of midwifery was largely in the hands of women; under their care labours were probably most often left entirely to nature, and owing to the absence of examinations and manipulations few opportunities for septic infection were accorded. In the second place the epidemics seem to have followed the institution of lying-in hospitals and the commencement of the teaching of midwifery largely, both in them and amongst the poor also. The middle of the eighteenth century is the period of work of Smellie, James Douglas, and later of William Hunter in London, and of Moss and Ould, the first masters of the Lying-in Hospital in Dublin; whilst between 1745 and 1765 the British Lying-in, City of London Lying-in, Queen Charlotte's, Royal Maternity, General Lying-in, and Dublin Lying-in Hospitals were all founded.

The prevalence of puerperal fever in lying-in hospitals continued until the introduction into them of antiseptics. Thus Dr. Cullingworth records that at the General Lying-in Hospital the death-rate from 1833 to 1860 was 3 per cent., and from 1860 to 1877 was 1·7 per cent. The hospital was closed in 1877, and when reopened antiseptics were used from 1880 to 1884, the death-rate was ·6 per cent., and from 1884 to 1889, while perchloride was used, it was only ·4 per cent. For the City of London Lying-in Hospital Dr. Godson gives even more remarkable figures. Up to 1870 the death-rate was as high as 1 in 19; from this year onward, in spite of frequent alterations and improvements, and the expenditure of a large amount of money, the mortality scarcely diminished, reaching in 1882–3 as high as 1 in 22. In 1886 antiseptics (perchloride) were introduced; in 1886–96 there were 4608 confinements with 11 deaths, a mortality of 1 in 419, and in the five years 1892–6 there were 2392 confinements with only 3 deaths, none of these being due to sepsis. In the Rotunda Hospital, intern and extern departments, out of nearly 4000 cases during two years there were no deaths from sepsis.

These numbers clearly show that though the lying-in hospitals were no doubt at their establishment responsible for a large increase in puerperal fever, at the present day, by means of the proper use of antiseptics—of transcendental cleanliness, as Matthews Duncan termed it,—they have attained a safety which is not approached by the average of private practice.

In 1847, the year of Semelweiss's statement of the cause of puerperal fever, the death-rate in England from this disease was 1·5 per 1000 births. It remained about or below 2, rising in 1874 to 3·6 per 1000, and again in 1881 and 1882 to 2·6 and 2·9, at the very time that the mortality in lying-in hospitals was beginning to decrease.

In 1893 it reached 3·3 per 1000 births, a mortality higher than it had been since 1847, save for the one year 1874. Since 1893 there was a steady though slow decrease, most marked in London, least so in the country districts; this is so far satisfactory, but this alteration is very slow and very late in commencing. Doubtless a large element in the continued prevalence of the disease is the midwife, in whose hands much of the practice in the country districts lies, and who too often possesses that little knowledge which is so dangerous; for while lacking the knowledge of the proper use of antiseptics, she is too apt to make a show of learning in another direction, by making vaginal examinations with unclean fingers. But there is a very considerable element in the fatality of puerperal fever which is due to the medical man, and much improvement might result from more care in the two directions of prevention and cure of the disease; the former by more careful use of antiseptics and more careful delivery of the placenta and membranes, the latter by more prompt and thorough treatment.

First, with regard to the prevention of sepsis, the principles of the uses of antiseptics are so thoroughly and frequently impressed on us that it would be waste of time for me to say much of them. There is no doubt that many medical men still use them inefficiently or not at all,—more often, I believe, from want of care than from want of knowledge. Cullingworth says of them, "The methods employed by many who would be ready to proclaim their belief in antiseptics, and who assure one they have used every antiseptic precaution, are often so crude as to be a ludicrous travesty of genuine antiseptic midwifery."

Another point in which I think it probable that many practitioners err is in unnecessary and careless interference with labours. Another writer has spoken of "the usually septic forceps removed from the great-coat pocket, and introduced by the too often dirty hands of the practitioner in nine cases out of ten simply because he is in a hurry.

With regard to antiseptics I would urge—

1. That perchloride of mercury is by far the most efficient and most convenient antiseptic, both as a hand lotion (strength 1 in 1000) and as a douche (1 in 4000 or stronger).

2. That to sterilise the hands after a preliminary thorough scrubbing, immersion in 1 in 1000 perchloride must be continued for at least three minutes, and that three minutes is a much longer time than we are apt to think.

3. That a perchloride douche, 1 in 4000, during the first stage can do no possible harm, and may do much good.

4. That cleanliness continued after labour in the form of frequent washing of the external genitals and clean diapers should be impressed on the nurse, and that it is the practitioner's duty to see that it is carried out.

5. That instruments must be kept thoroughly clean, and wrapped in clean material, and should be boiled when there is any chance of their being dirty.

6. That Matthews Duncan termed antiseptics "transcendental cleanliness," thereby meaning that ordinary cleanliness is an essential part of the proper practice of antisepsis.

Secondly, with regard to the prevention of retention of placenta or membranes in the uterus. This consists in—

1. Leaving a reasonable interval after the birth of the child before expressing the placenta to allow a proper separation of placenta and membranes to take place. I consider half an hour to be a reasonable interval to wait.

2. The expression of the placenta by the method known as the Crédé method, though this is much older than Crédé's time, having been used in Dublin since about 1780.

3. Careful examination of placenta and membranes, and removal with the hand of any portion retained. The danger of sepsis from such introduction of the hand is much less than the danger of leaving placenta to rot in the uterus. Chloroform should be administered as rendering the process not only less painful, but also easier and more likely to be complete.

These three precautions sound so easy to carry out, but they are so easy also to omit. The first error the clerk at McKenzie's commits when he becomes confident of himself is to express the placenta after waiting only ten minutes; the second is to return home from a case, and tell the extern next day that Mrs. So-and-so has all the chorion retained. Unfortunately these errors can be committed time after time with impunity, but sooner or later the result comes—one of that clerk's patients gets puerperal fever. These omissions come from laziness and carelessness, a desire to get home to bed; let us avoid them from the beginning, for evil habits which we acquire now we shall carry away with us into practice later.

Turning to the cure, I believe that the great majority of cases of puerperal infection can be cured by prompt treatment. In every case where the diagnosis of septic absorption from the uterine cavity has been made, the uterus should be immediately explored under an anæsthetic. The uterine wall should be scraped with the side of the finger, the nail not being used, and all that can be thus removed taken away; when it is certain that nothing remains give a douche of 1 in 1000 perchloride of mercury followed by a little hot water. You have now done all you can to purify the uterine cavity, and all that remains is to keep up the patient's strength, and hope that you were early enough to prevent general infection.

In some cases the temperature will immediately fall, in many it will fall gradually in a few days, in a few it will not even commence to fall for some days. There is no need to despair of these, the cause of this persistent fever is most often, I believe, metritis extending through to the peritoneal surface and so causing perimetritis, and this will most likely be recovered from unless the infection is very virulent. No further treatment is necessary save light nourishing diet, regulation of the bowels, and daily hot vaginal douches of 1 in 4000 perchloride: the latter serve to wash away any discharges, and also act as a counter-irritant.

When it is evident that infection is general or pyæmic, the prognosis appears to depend on the power of the individual to resist the organism, and our main treatment must therefore consist of measures to support the patient's strength, and of good nursing. Antistreptococcic serum remains, and up to the present it must be acknowledged that it has not been a great success; two cases of recovery after its use for symptoms of puerperal pyæmia have occurred in the Hospital during the past two years, but in one of these it was not used until after the temperature had become normal. As explanations of the want of success may be suggested mixed infections, and that it is an antitoxin and not a bactericidin, or that if the latter it is not efficient in the human being. Lastly, in some cases of peritonitis following local suppuration in the pelvis, it is possible that abdominal section might sometimes be of use.

My desire in this paper has been to impress the dual nature of the cause of the disease. Too often, I believe, the importance of the retention of products of conception as a causative factor in puerperal fever is forgotten at the present day. As an example of its importance I may mention that out of ten cases of severe puerperal fever occurring in this Hospital during two years, in seven, placental remains were either removed during life or found post mortem, and to this may be added a very considerably greater number of slight cases in which an early exploration of the uterus resulted in a favourable issue. Out of the seven cases five were fatal, and in none of these was the uterus explored earlier than the ninth day. These numbers, though small, point clearly to the importance of this factor in puerperal fever, and to the possibility of cure by early evacuation of the uterus.

The Cholera Epidemic of Last Autumn in Palestine.

By E. W. G. MASTERMAN, F.R.C.S., D.P.H.Cantab.

(*Concluded from p.* 62.)

IN *Jaffa* itself the epidemic reached its height in the middle of November. All private reports state that the official figures regarding the disease and death-rates are far too low. The actual numbers reported between October 19th, when the disease was declared, and December 27th, when the last reported case happened, were 430 cases and 272 deaths; these figures might safely be doubled. But statistics can give no idea of the state of misery and panic. Nearly all the shops were closed; people were afraid to go even to the druggists or to summon a doctor for any complaint, because if they did so they were liable to be followed home, their whole household declared suspected, and to have a cordon put round, making all communication with the outside impossible. Some people under such circumstances were found dying of positive starvation, and to avoid such discomforts bodies were secretly buried in gardens or in the sea-shore sand. It is narrated, and generally believed, though I know not on what evidence, that a child died of cholera in a large Moslem house, and to avoid the inconveniences of quarantine the friends threw its body into the well, with the result that almost every member of the house died. In the same way a village woman in another place was found tramping through the land with her dead child tied in a sack, that the police should not declare her village infected. From these towns the disease spread all over the maritime plain (the "Plain of Sharon"), a large proportion of the villages suffering. The Palestine Exploration Fund, which was engaged in "digging" at the site of ancient Gaza, had to cease work. One day one of the workwomen retired from work in the trenches at midday, and was dead a few hours later. That evening there was a marriage in the village, and two days later the bride was dead. The staff had hastily to strike camp and make for Jerusalem, enduring, however, *en route* the discomfort of ten days' quarantine. Since this the appearance of thirty new graves shows how great was the mortality in this small village.

While the disease was thus expending its force in the south an independent wave of epidemic had made itself manifest in the north, *i. e.* in Galilee. Here the source of infection was from east of the Jordan, where probably the disease was started by some returning pilgrims from Mecca. It invaded several Bedouin encampments, and attacked the staff of workmen on the new railway line from Damascus to Arabia at Ammān (the Ramoth-Ammon of the Bible). It is stated that the small stream the *Zerka* (= the Jabbok), which goes through *Ammān*, was infected through some Bedouin washing in it clothes from a number of cholera victims whom they found in a deserted encampment. Carried either by the Bedouin or the workmen, the disease passed north-westwards, and after infecting some smaller villages attacked the little town of Tiberias. This place, lying some 600 feet below the level of the Mediterranean, is in a peculiar degree fatally situated in view of such an outbreak, inasmuch as most of the inhabitants, besides being wretchedly poor and debilitated by the tropical heat, habitually drink the water of the lake, into which their drains run, and in which their clothes are washed. A terrible epidemic occurred. Out of about 6000 inhabitants, I learn from Dr. Torrance, the doctor of the Scotch mission there, who himself lost his wife in this epidemic, that no less than 600 died, giving a death-rate of one in ten, and disease-rate perhaps as at Gaza, one in seven. The disease, too, lingered much longer than in most places, visiting in turn most of the neighbouring villages. The people were reduced to the utmost want, even though voluntary assistance was, as far as possible, sent from neighbouring towns; for example, the Jews of Safed greatly helped their co-religionists in Tiberias. Sixteen days' quarantine, a preposterously unnecessary length of time, was insisted upon for all those who would leave the town. This, as usual, was not infrequently avoided by natives who could afford to pay, but was insisted upon up to the hilt with all Europeans—even medical men. At Nazareth only one (non-fatal) case has occurred—a refugee from Tiberias, who sickened in an hotel. An English traveller and his wife had the misfortune to be staying at the hotel at the time, and it throws a light on Turkish methods that *after* these travellers had performed the full quarantine demanded, the authorities compelled them to pay nearly £20 *baksheesh* before they were allowed to proceed on their journey. As the disease began to die down in the district around Tiberias towards the end of December it made its way south and west, infecting a number of villages to the south of the Plain of Esdraelon. In one of these alone, where there is an English lady residing, I hear there were 300 deaths. Finally, either from here or from the Jaffa side, the city of *Nablous* (the ancient Shechem) was attacked towards the end of the year, and well into January the infection has continued to spread. This place, however, is fairly high (1870 feet), and is well supplied with excellent springs, and neither here nor elsewhere on the high ground has the cholera done anything like the havoc it has in the plains.

At the beginning of December Jericho was declared infected, the disease having been brought over the Jordan by soldiers returning to Jerusalem—ten of whom died in Jericho itself. When I was there on December 31st I heard, on what I thought reliable authority, that forty-one had died, but since then I learn that a Greek lady who was in quarantine there counted herself no less than eighty-three funerals, so that the mortality must have been very great for so small a village (about 300 souls); probably many that died were, like the soldiers, returning from the infected areas east of the Jordan. One would have thought that if ever there was a place where a strict land cordon could be obtained, it would be at a deep swift river with very few bridges and fords; but at the Jericho-Jordan bridge the usual distribution of *baksheesh* occurred, and a continuous stream of people passed through without doing any quarantine at all. During this same month cholera entered Damascus, brought in the first instance from *Ammān* by some Italian workmen on the line, but, as far as I can learn from my friend Dr. Mackinnon in that city, it has not assumed a very wide-spread epidemic, though it has attacked a few neighbouring villages, and is still—at the end of January—in the district.

I have left to the last our experiences in Jerusalem, as they are rather serio-comic than tragic, as is much I have narrated. The governor, in a manifesto declaring that there was quarantine against Jaffa, stated that, "through the mercy of God," so far Jerusalem had been spared. He emphatically spoke the truth in one sense, for it was through very little management on the part of man. We had cholera on all sides, not only at Nablous, Hebron, Jericho, and Jaffa at the four points of the compass, but within a very few miles in villages of the district; indeed, some three or four cases actually got into the city and died of cholera, but no fresh case arose in our midst. Credit must certainly be given to the prompt isolation of these cases; but the chief safety lies in our lofty situation, the fact that the winter's cold and rain (the latter unusually heavy this year) had set in before the disease came to our neighbourhood, and lastly to the fact that most people in the "Holy City" are rather particular about their drinking-water, and obtain it either from cisterns carefully looked after, or from spring water conveyed to the city in iron pipes, or, as is the case with many of the well-to-do, carried in jars direct from the springs. But though we escaped the disease this autumn, the panic and precautions were at once terrible and ridiculous. The first step taken was the peremptory stopping of the trains, all trade and traffic with Jaffa being interdicted. The price of provisions went up with a bound to unprecedented heights, and the normal semi-pauper condition of the average dweller in the city became aggravated to the verge of starvation. When, after some emphatic protests from the foreign consuls, the freight trains were allowed to resume their runping, the goods had to be transferred from one train to another *en route*—the engine apparently being suspected as a possible cholera patient! The amusing thing is that I understand that this transference actually occurred at *Lydd*, where the cholera was so severe. Then the mails were considered most dangerous; all parcels, even from Europe, were forbidden, and a native qualified doctor was employed at the entrance to the mountains—where the road quarantine was made—in the intellectual task of stabbing a knife through every letter, after which the mails were "disinfected" in a childish kind of way with a handful of sulphur.

The medical practitioners of Jerusalem, to the number of some two dozen, were summoned to discuss the situation, and each one made some new and original suggestion—duly recorded in French for the edification of the Pasha. When two dozen medical men, of all nations and qualifications (or no-qualifications), get together to each one show his special ability to deal with the situation (an entirely new one to two thirds of them, as cholera had not been in South Palestine since 1865), it may be imagined some very amusing and original ideas were recorded. But the most original thing of all was that the masses of Jerusalem got it into their heads (it is an old

tale in India—revived not long ago in Egypt) that the medical men had agreed on a most drastic plan of campaign, namely, to quietly *poison off* all those who showed any symptoms of the disease. This in the twentieth century, in a city inhabited very largely by Europeans! The report was firmly believed by the majority of the people, Moslems, Christians, and Jews, and a large proportion of the medical men in the city were quite deserted of their patients. A most elaborate story was told of how one particular medical man had dropped from his pocket some notes of how to treat cholera, and on a dispenser being sent for, he stated the medicine was evidently intended to kill, not cure. For some reason the English doctors were thought, at any rate by many, to be not quite so black, and our dispensaries and hospitals continued to be attended. Indeed, several of the most avoided medical men sought for a public assurance from us to their patients that such a plan had never been made. At the height of the excitement a story got about that a patient (or two or three as the tale grew) had been taken down to an open spot outside the walls, and after being drenched with petroleum had, under medical orders, been burnt to death. The origin of the story was probably due to the burning of the clothes of a patient from the east of the Jordan who had died of the disease soon after his arrival. The serious aspect of all this foolish credulity was that many thousands of people had resolved at all costs to keep secret any cases of cholera that should occur in their houses—a course which, if followed, would have paved the way for a big epidemic. The military officer in charge of one of the chief quarantine stations got colic one night, and the medical officer, hearing of it, went to his tent to offer his assistance. What was his astonishment at being received with a loaded revolver, and the threat that if he did not clear out at once he would be shot! The doctor, standing afar off, advised his patient to take a little brandy and hot water and apply external heat—advice which the panic-stricken soldier followed with success, but nothing would induce him to run the risk of the doctor's medicines. Semi-quack preventives were freely sought after. Naphthalene, claimed as a sure safeguard, was bought up with the greatest haste; citric acid, another vaunted good, was cleared out of all chemists; and, with more sense, carbolic soap, selling at about 250 per cent. its usual price, brought a small fortune to those happy dealers who had it in stock. All the carbolic acid in the city—little enough—was impounded by the municipality. As regards food, the most amusing tale I know is one for the truth of which I have good authority. One of the leading consuls here, more than most alarmed at the thought of cholera, had brought to his dinner one evening a large boiled fish. On the cover being raised he exclaimed, "Whence is this fish?" "From the Jordan," was the reply (this was long before there was any disease in Jericho). "Oh, horrible!" he exclaimed; "is there not cholera in Tiberias? how can it be safe to eat a fish from the Jordan!" And then another, with the aid of his cavasses (*i.e.* Turkish soldiers supplied by the Government to protect consuls), carried the fish and dish and all into the garden, dug a large hole, and buried the lot deep in the earth!

What inland quarantine means under Turkish rule may be described by two or three instances which I have at first hand. The first happened in 1895. In the autumn of that year I disembarked at Beyrout with a view of proceeding to Damascus. On the day of my landing the authorities of Beyrout had learned that a servant of a wealthy Turk at Damascus had had an attack of colic, and as they thought it *might* be cholera (there was none in the land then) they suddenly ordered that all the passengers arriving that evening by train from Damascus should be quarantined. Thus it happened that when the train reached Beyrout station all the unfortunate passengers, very few of whom had come the long eight hours' journey from Damascus, were marched off to the squalid quarantine station and dumped down there without any kind of provision for either eating or sleeping. Among them were several leading members of the foreign community at Beyrout, all ladies, who had got into the train at the *last station* before Beyrout, having driven out there for the air. They had to communicate with their friends as best they could, and late at night got rugs and food; they did not, however, escape from their semi-imprisonment for thirty hours or more. The running of all trains was peremptorily stopped for some days until the railway company commenced to sue the municipal authorities for damages. Meanwhile the sick man in Damascus recovered, and turned out to have had not cholera, but the very ordinary results of an over-feed. Some two months later, when a small though widely scattered epidemic of cholera actually did visit Damascus (I myself, though a new-comer to the city, attended some seventeen typical fatal cases), the Government shut their eyes, and I was even privately informed that they did not want to see any certificates of deaths as due to Asiatic cholera!

But to return to the recent epidemic: some friends of mine coming to stay the winter in Jerusalem landed in Jaffa just as the epidemic was commencing, and after waiting some weeks, at last obtained, as a great and exceptional concession, the permission to come through the cordon without undergoing the ten days' quarantine. This required the expenditure of hard cash in more ways than one. For one thing, for the road between Jaffa and Jerusalem they had to engage three carriages,—one to take them to the limits of the cordon round Jaffa; another which they had to hire for *ten* days, as the carriage and horses had to do quarantine for that period between the Jaffa cordon and the quarantine station at a place called *Babelwad*, at the entrance of the pass in the mountains leading up to Jerusalem; and lastly, one to take them thence to Jerusalem. The middle carriage had to pass the outskirts of a village in which a number of cases of cholera had occurred, and my friends narrated to me with much amusement how, on nearing the village, the driver enveloped his mouth and nose in a cloth saturated with naphthalene, and galloped his horses for all they were worth past the dangerous area. When finally the travellers reached Jerusalem they were driven at once to one of the hospitals, given hot baths, and the clothes that were on them taken away for disinfection, after which they were allowed to help themselves out of their boxes, not even in pretence disinfected, to the very clothes they had worn almost all the time in Jaffa; and then, in the same carriage in which they had come, they went to their hotel! Another friend of mine, who had just dressed similarly in his ordinary clothes after his bath, was called back to wash his hands in spirits of wine because he had put it in his pocket just before leaving the building. What idea lay at the bottom of all these wonderful measures who can say? To disinfect the clothes in which the people had arrived, and then allow them to take disinfected clothes from their boxes, dress in them, and go on to the hotels in the very carriages they had travelled in up from the quarantine station, bespeaks a queer mixture of ideas as to the nature of infection. The same may be said of many of the precautions at the quarantine station. Letters brought from presumably infected areas were thrown on the ground and picked up with a bent stick or a corner of the robe of the quarantine attendants. The same queer mixture of ideas regarding infection and disinfection was shown in the brilliant idea of burning a small handful of sulphur *under* a railway truck to disinfect its contents, and that too, on at least one occasion, when the contents happened to be carbolic acid, going to Jerusalem for disinfecting purposes! In the same way the precautions taken in Jerusalem were almost limited to placing a number of black watchmen at prominent corners to prevent boys and men doing what is technically called "committing a nuisance,"—a step certainly in the right direction the few weeks it lasted (alas! long over), but very unlikely to in any way affect the course of cholera. Neither this nor the extensive whitewashing of the house fronts could affect the accumulated filth in hidden corners and beneath the surface—in half-blocked, leaky sewers.

An early and somewhat original precaution was the enforced exodus of all the professional beggars from the city—a straggling and dismal procession of the blind, the lame, the paralytic, and the lazy, slowly creeping clear of the suburbs under the escort of half a dozen mounted police. They have, however, I may add, all returned or been replaced long ago.

One of the few truly sensible things, and that I imagine not a Government measure at all, was the free distribution of some really excellent information about the actual nature of cholera, its causes and prevention, in the form of an Arabic leaflet, the translation of a paper by, I am glad to say, a fellow-countryman of ours in Egypt.

So far all has gone well in Jerusalem, and the unusually heavy winter rain (already twenty inches, and much more to come) has, in combination with the cold, apparently stayed the disease all over the land. But as I write I fear there is little likelihood that so widespread an epidemic, entirely uncontrolled as it was in the country districts, has finally come to an end in three months, and we must be prepared for a recrudescence with the onset of the warm weather—in, let us hope, a less virulent form. Perhaps my medical friends will not say of me what a lady in Jerusalem remarked when I made a similar statement during a lecture I gave on cholera,—"I think it is very presumptuous of him to say anything of the sort!"

JERUSALEM;
January 29th, 1903.

Reviews.

PRACTICAL HANDBOOK OF THE PATHOLOGY OF THE SKIN. By J. M. H. MACLEOD, M.D. (H. K. Lewis, 1903. Price 15s. net.)

Dr. Macleod claims that his book is written on lines unique in this, or, so far as he is aware, in any other country. A perusal of the book leads us to consider this claim as fully substantiated. For the first time in our experience we have found an account of diseases of the skin which follows a pathological, or more strictly an anatomical classification, based no longer on clinical appearances, but on the essential changes in the various structures. The scheme involves some changes in arrangement, which at first appear somewhat startling to the untutored mind, but are so obviously correct when they are considered from the author's point of view, that one wonders that they have not been made earlier.

The book begins with chapters devoted to the general technique involved in the pathological study of the skin, this being, as the sub-title indicates, one of the principal aims of the author. A study of the histology and development of the normal skin follows, these two sections occupying the first eighty pages. The remaining three hundred are devoted to the study of the pathological conditions. Every chapter contains a series of elaborate instructions as to hardening, fixing, cutting, and staining sections, a feature which adds enormously to the value of the book as a laboratory companion, but does not increase the ease of the reader, who is constantly interrupted by the intrusion of these details. We could wish, for the sake of the popularity of the book, that these could have been placed in a separate section. But this is a defect perhaps inseparable from the author's design, and we offer the amendment in no spirit of criticism. Of criticism, indeed, there is, we think, little needed. The subject of each chapter is treated exhaustively and in full detail, but the author is concise, and on the whole conclusive. There are, however, two points on which we should like to make some remarks. The first is to point out that in his chapter on pathological changes in the blood we can find no mention whatever of myelocytes, though he incidentally describes other changes which occur in myelogenous leukæmia. Even though there be no skin disease which is as yet associated with the presence of these cells in the peripheral blood, we venture to think that he is not justified in leaving out all mention of them in a chapter devoted to the pathology of the blood. Secondly, we should like to draw the author's attention to the chapter on carcinoma of the skin. It is a difficult subject to handle clearly, and Dr. Macleod has evidently found it so. As far as we can make out he has chosen to follow Continental rather than English ideas upon the subject, but repeated reading of his remarks has left us with no definite comprehension of his meaning. He divides carcinomata of the skin into three forms:—(1) Tubular carcinomata; (2) Pavement epitheliomata; (3) Vegetating epitheliomata. It is true he remarks that the division is arbitrary, but says it is useful for purposes of description. His descriptions which follow leave us notwithstanding quite in the dark as to the position of rodent ulcer, and there seems to be only a difference of degree between his second and third varieties. Again, he states that rodent ulcer "has its origin generally in the surface epithelium." This statement is so opposed to the teaching of our English text-books that he should, we think, have adduced some evidence or quoted some other authority. His own bald statement is hardly satisfactory.

The illustrations are numerous, and for the most part very clear and admirably reproduced. The printing is good, and very free from error; "tenatome" (p. 9), however, should surely be "tenotome."

We believe that the book is certain of success when it becomes, as it deserves to be, widely known.

THE KING'S SANATORIUM: ESSAY AND PLANS FOR THE ERECTION OF A SANATORIUM FOR TUBERCULOSIS. By EGBERT C. MORLAND, M.B., B.Sc., associated with GEOFFREY MORLAND, Architect.

This essay, which is reprinted from the *Lancet* of January 3rd, gained the third prize in the international competition instituted by His Majesty the King. It is in all respects a model of what such an essay should be—admirable alike in its conception and execution; the clearness of the descriptions of the details of the building, and the general absence of verbosity and redundancy, must have been very grateful to the Committee of Selection, who had to examine also the treatises of 180 competitors.

Dr. Morland starts by saying that in his opinion the "ideal sanatorium consists of a series of isolated huts, with windows on all four sides, in which the patients spend their whole time, except when they are actually out in the grounds." This ideal is obviously unworkable except on a small scale, so that for the 100 stipulated beds a compromise has to be effected; so he takes as his unit "a room facing south, with unobstructed aspect, with a large window space, with a door on the north side opening on to a wide corridor, in which there is a large window exactly opposite the door;" and he builds his sanatorium of "two diverging wings, each containing forty-four such units, the whole forming a long curved south frontage." Between the two wings is a library, abundantly supplied with window space, which is the only common sitting-room provided. "The dining-room is situated to the north of the east wing, and is accessible by covered ways"—covered, that is, from rain and snow, but open at the sides. This room is to be large enough to accommodate all the patients at once, and three sides "consist chiefly of windows." The kitchen block is immediately behind this room. A verandah, for whose

presence Dr. Morland apologises, we think somewhat unnecessarily, as interfering with the perfect ventilation of the ground-floor rooms, runs along the whole south frontage. In the grounds, which are intersected with numerous walks, day huts are provided; these are "raised from the ground on piles, on a framework of wood with a painted galvanised iron roof;" they are open to the south, with large sash windows to the north. Each is to contain a wicker reclining chair and a writing-table, and each has a 16 candle-power lamp. The arrangements of each bedroom are described in detail, the object aimed at being the maximum of comfort with the minimum of furniture. The whole building is to be heated by a system of hot-water pipes at low pressure, with a radiator in each room. Every conceivable necessity of such an establishment is provided for, and the care with which all the details are worked out is most admirable. In fact, we believe that a practically ideal sanatorium could be constructed on the exact lines which Dr. Morland suggests. In the conditions of the competition room had to be provided for twelve well-to-do patients, a scheme which anyone who has had to do with the working of such an institution must recognise as quite impracticable. Dr. Morland suggests an annexe, built on much the same lines as the main building, but with rather more luxury of detail.

We repeat that the sanatorium here sketched seems to us to be ideal, combining, as it does, simplicity and economy of construction, ease of administration, and those conditions of life which such establishments are intended to supply, and we congratulate Dr. Morland on the official recognition that his admirable piece of work has won.

Amalgamated Clubs.

RUGBY FOOTBALL CLUB.

"A" TEAM.

ST. BART.'S "A" *v.* MERCHANT TAYLORS' SCHOOL.

Played at Bellingham on Wednesday, February 25th, in very windy weather. In the first half the School had the advantage of the wind and scored a goal. In the second half Bart.'s proved the quicker outside, and tries were scored by Townsend and Keats, both being converted by the latter.

Result: St. Bart.'s 2 goals, School 1 goal. Team:

A. J. Kendrew (back); C. H. Cross, E. Harrison, B. A. Keats, F. H. W. Brewer (three-quarters); R. S. Townsend, W. H. S. Burney (halves); A. J. Symes, H. Hoskyn, S. Trevor-Davies, H. R. Snowdon, — Fuller, E. R. Jones, — Haman (forwards).

INTER-HOSPITAL HOCKEY CHAMPIONSHIP.

FINAL ROUND.

ST. BART.'S *v.* ST. THOMAS'S HOSPITAL.

This match was played at Richmond on Friday, March 13th, before a goodly number of spectators, including one of the hospital teaching staff. The president of the club (Dr. H. Morley Fletcher) and two more of the staff would have been present but for a most regrettable accident. The game was a very fine one to watch, and was very fast throughout. The bulley-off took place soon after 3 o'clock, and Bart.'s made a determined rush to the Thomas's goal, but Thomas's were not to be caught napping, and cleared finely, taking play back to mid-field. But Gray on the right wing made a pretty run, which, however, only resulted in a fruitless corner. Then Bart.'s were penalised twice in succession, and Thomas's swarmed round our goal; but Barton, who throughout was quite the hero of the match by playing a truly magnificent game, cleared well. Thomas's, however, were not to be denied, and came back to the attack, but Coalbank cleared well. Then Griffin got away with a pretty bit of work, but hit too hard, and Thomas's came back to the attack. Then, helped by Page giving "sticks," Thomas's literally buzzed round our goal like a swarm of bees, but Haines and Barton cleared, and unfortunately, just as we got nicely up the field once more, Glenny gave "sticks," and Thomas's regained all their lost ground, and they even shot well at our goal, but their shot went wide. Thomas's were feeding West, their Midlands representative, for all they were worth; he was playing a fine game, but, luckily for us, his next shot again just missed our goal. Next, Coalbank and Furber were at fault at back, but Glenny cleared finely with one of his famous hard hits. Thomas's, however, came back to the attack, but Raikes and Gray transferred play back again to the Thomas's "25" line. Then West got the ball, and made a fine dash for them, but Whitly, who did his work in goal very well throughout, saved well. Thomas's kept up the pressure, but our defence was too good. Barton again cleared, and we got to the Thomas's circle, but Page hit too hard, and a "behind" resulted. Thomas's then got West off again, but Page brought him up finely, and passed the ball well to our forwards, who were scrambling round the Thomas's goal; and eventually, amid great cheers, Griffin put the ball into the net, and so gave us the lead. This set Thomas's on their mettle, and, helped by Glenny missing an easy shot and giving "sticks," they rushed us back to our goal, and Whitly cleared well, thereby also setting our forwards going; but their rush this time seemed rather half-hearted, but nevertheless they got to the Thomas's circle, but Griffin just grazed the post on the wrong side. From the bulley-off for about three minutes our forwards got cramped out of their places and steadily lost ground, but Glenny revived them with one of his finest bits of work; but Haines unfortunately did not take his pass, and West got off for Thomas's, but was brought up by Coalbank. We next saw our captain doing a fine bit of work on the wing, which transferred play to the Thomas's circle, but a corner was the result, and our forwards did not avail themselves of Gray's fine hit, missing the ball one after another, and Thomas's worked us back to their "25" line; but Glenny made a good dash for goal, but a "behind" once more resulted. From the bulley West again got off, but was brought up very finely by Coalbank, who again set our forwards going, and Thomas's goal-keeper Neil was called upon to save, which he did very well. Hill was next very prominent by claiming a "foul;" this helped us materially, but Glenny missed an easy chance at goal. This let Thomas's start another dash for our goal, but Coalbank was again to the fore. Next by some good work by Hill we once more got to the Thomas's circle, but were driven back to halfway, where play for the first time in the game stayed until the call of half-time, leaving us feeling pretty "cooked," but nevertheless leading by a goal to *nil*.

From the bulley-off we again got away, headed by Raikes, but Thomas's backs were still one too many, and returned the ball to their forwards, but Furber cleared well, and Thomas's once more came on, and Coalbank was again called into prominence. Then our forwards, again headed by Raikes, got off, but Thomas's goal saved well. We still maintained the pressure, and Thomas's goal gave "sticks" right on their line, but we could not get the ball through even then. Soon after this West again got going, and it took the combined efforts of Page, Barton, and Furber to stop him, but our trusty henchmen did what was required of them. Then Haines got the ball and made a fine dash down the field, but our other forwards were not there, and so the ball came back to the Thomas's forwards, and Page cleared very well indeed, thereby setting Griffin going; the latter passed well to Raikes, but his shot went over the goal. Then, by dint of Page giving "sticks" and Hill a "foul," Thomas's came to our territory once more, but Furber cleared. However, we got back to the Thomas's circle, but Raikes shot wide. Thomas's cleared, but Glenny got going only to be stopped by the Thomas's backs. Then Furber made a mistake and nearly let Thomas's in, but our defence prevailed, and Glenny got going only to be "returned empty." Then Coalbank muddled the ball, and a corner resulted; but Glenny cleared again to be driven back, and Coalbank made amends for his last mistake. Then Haines made a fine run, but another "behind" resulted. Next Thomas's came back earnestly to the attack, but Whitly saved grandly, and Barton, ever to the fore, cleared well. Then Hill got his forwards going, and after a fine run by Glenny Griffin notched our second point. Both sides were now showing signs of "bellows to mend." However, Thomas's came back to the attack, and Whitly again saved magnificently, and we gained ground only to lose it again by Furber furiously waving his stick round his head,

but Glenny and Page cleared well. Play ruled fast first round one goal and then the other, and Whitly was once more called upon to save, which, as usual, he did well. Eventually time was called with Thomas's pressing but with our defence unbroken, leaving us winners and champion hospital by 2 goals to *nil*.

A truly magnificent game from beginning to end. Our team one and all played well. Barton, Whitly, Coalbank, and Raikes (our international representative) were perhaps the pick.

We offer our very heartiest congratulations to Captain H. B. Hill on the success of his team, and may they repeat the event next year. For Thomas's, West was quite their mainstay; Footner at half with Carver at back and Neil in goal were also good. Team:

F. Whitly (goal); M. R. Coalbank, L. G. H. Furber (backs); H. B. Hill, B. H. Barton, G. F. Page (halves); H. Gray, C. J. Raikes, W. B. Griffin, E. J. Glenny, and R. L. Haines (forwards).

Notes.

MR. MCADAM ECCLES and Mr. W. D. Harmer have been elected Demonstrators of Operative Surgery.

* * *

DR. F. A. BAINBRIDGE has been elected Casualty Physician in place of Dr. Thursfield, whose term of office expires at the end of March.

* * *

THE Kirkes Scholarship has been gained by Mr. C. M. Howell, to whom we offer our sincerest congratulations.

* * *

WE publish in another column two letters from Mr. Sydney Holland. The second of these was sent to us after we had written privately to Mr. Holland explaining our position, and expressing our very sincere regret that anything which we had written should have appeared to him to have been discourteous, and assuring him that nothing had been further from our intention than to stir up any ill feeling between ourselves and the London, or to be rude to him personally. We confess to having had the rashness to indulge in a very mild witticism, and we are sincerely sorry that it should so unfortunately have miscarried.

* * *

To the Editor of the St. Bartholomew's Hospital Journal.

DEAR SIR,—It must have struck many of your readers how much valuable instruction is lost, by teaching children to learn nursery rhymes which are quite nonsensical. I have therefore taken the liberty of forwarding to you some samples of nursery rhymes specially suitable for the instruction of children of medical men. Seeing that the jingle and rhythm of the old, out-of-date, forms have been so successful in the past, I have endeavoured as far as possible to imitate them, as you will see. At the same time, I have not hesitated to alter, and, I flatter myself, improve upon them, where I have thought it desirable to do so. Trusting that my small efforts may lead others, more skilled than I, to elaborate this idea, and possibly to extend it to the families of other than medical men,

I am, yours faithfully,

PATERFAMILIAS.

EXAMPLE NO. 1.—Suitable for the family of an operating Surgeon with a leaning towards gall-bladder surgery.

"Sing a song of sickness, yellow in the eye,
Four and twenty gall-stones, choledecto-my!
When the wound was opened, the bile began to flow;
When the deuce it's going to stop the doctor doesn't know!"

EXAMPLE NO. 2.—Particularly adapted for the rather older children of a health resort Physician. (N.B.—The name of any particular Spa, or some simple modification of it, may be substituted for the one given in the text.)

"Drive a good horse, at Bathton for choice,
Advise a rich lady to take a full course;
Gout in her fingers, and gout in her toes,
She should take waters wherever she goes."

EXAMPLE NO. 3.—For the children of an Orthopædic Surgeon, to be used whilst passing the usual daily hour on the backboard.

"Pussy cat, pussy cat, whence come you, whence?
I've been up to London to see Herr L-r-nz.
Pussy cat, pussy cat, what did he do?
He pounded a little child nearly in two!"

EXAMPLE NO. 4.—To be sung to the infants of a Specialist in Dermatology.

"Three blind boils!
See how they run!
They all ran, after the farmer's wife
Had cut off their heads with a septic knife;
You never saw such a mess in your life
As three blind boils.

EXAMPLE NO. 5.—This will be found to be suitable for the grown-up children of any hard-worked General Practitioner, whose night bell has been familiar to them from their earliest days. As a recitation for small tea parties it is particularly effective, especially if given with the simple dramatic directions, which are purposely put in *italics*, in case it is thought better to omit them. (N.B.—It will be noticed that line 2 is not strictly metrical. This, however, could not be avoided, and, on the whole, tends to make the little recitation more realistic.)

(*Softly*) Hickory, (*more loudly*) dickory, (*shout this out*) dock! (*Pause!*)

(*Place the hands at each side of the mouth to imitate a person calling out something from a distance off, and raise your voice.*)

Please-will-you-come-at-once-to Mrs. Block!

(*Slowly and quietly*) The clock struck one!

(*Very deliberately*) Down the doctor came.

(*The next line may be made very effective by yawning deeply whilst saying it slowly and in as philosophic a tone as you can.*)

"Hee'ory, dee'ory, do'."

Abernethian Society.

ANNUAL REPORT FOR SESSION 1902-3.

DURING the past session the Society has held twenty ordinary meetings and one special general meeting. Three of these meetings have been devoted to sessional and mid-sessional addresses, delivered by Mr. Bruce Clarke, Dr. Griffith, and Sir William Church respectively.

At the usual weekly meetings twelve papers have been read, one by a member of the senior staff, seven by members of the teaching staff, three by members of the junior staff, and one by a member of the Society at present unconnected with the Hospital. Five clinical evenings have been held, at which twenty-seven cases and several specimens have been shown, the cases being derived from the wards and out-patient departments of this and other hospitals. The attendance has shown an increase since last year, the average per meeting being 45'5—maximum 120, and minimum 22. During the past year 33 new members have been admitted.

Of special business the alteration of the rules, which was authorised to be undertaken at the special general meeting of March 25th, 1902, has been completed, and the revised rules have been adopted and printed on cards and hung up.

A new notice board has been erected in the resident staff quarters.

In accordance with the wishes of the Society expressed at the last general meeting, 25th March, 1902, the names of the portraits in the Society's room have been affixed thereto. The Society has received numerous autographs of famous past members from Mr. Marsh, and it has been decided to start a collection. From the same quarter the Society has received an engraving of John Abernethy, which has been framed and hung in the Society's room.

A. DENHAM WHITE, *Hon. Sec.*

As adopted by the Society.—A. J. FAIRLIE CLARKE.

LIST OF OFFICERS.

Presidents.—Mr. H. E. G. Boyle, Mr. E. E. Young.
Vice-Presidents.—A. Denham White, W. H. Hamilton.
Secretaries.—Mr. J. R. R. Trist, Mr. E. H. Shaw.
Additional Committeeman.—Mr. H. Gourvain.

J. R. RIGDEN TRIST, *Hon. Sec.*

Correspondence.

To the Editor of the St. Bartholomew's Hospital Journal.

DEAR SIR,—My attention has been drawn to the following sentence which appeared in your February number:—"But it unfortunately happened that our appeal interfered with the regular quinquennial appeal of the London; and the Chairman of the London, who thinks all is fair in love, war, and charity, laid his plans accordingly. A regular attack was organised, and the batteries were opened as soon as the Lord Mayor announced his readiness to head an appeal."

May I be allowed to protest against its exceeding rudeness, and to state that it is as untrue as it is rude? I did not organise any attack on Bart.'s.

Yours faithfully,
SYDNEY HOLLAND.

March 25th, 1903.

To the Editor of the St. Bartholomew's Hospital Journal.

DEAR SIR,—I am extremely obliged to you for your courteous and kind letter, and I am sorry I took seriously what was only meant as chaff. Nothing can be further from my wishes than that there should be any ill feeling between our two great hospitals.

Believe me,
Yours faithfully,
SYDNEY HOLLAND.

The Rahere Lodge, No. 2546.

A MEETING of the Rahere Lodge, No. 2546, was held at Frascati's Restaurant, Oxford Street, W., on Tuesday, February 10th, W. Bro. Holden, M.D., W.M., being in the chair. Bro. M. Dale Wood, M.D., was raised to the rank of Master Mason, while Dr. W. Jobson Horne was initiated into Freemasonry. A grant of a guinea to Our Brother's Bed in the Home for the Dying was voted unanimously. It was announced that the promotion of the William Harvey Chapter had been taken over by the Sancta Maria Lodge. A considerable number of brethren subsequently dined together.

Examinations.

Treasurer's Prize.

M. Fawkes.

A special prize was awarded by the Lecturers in Anatomy to E. M. Woodman.

Foster Prize.

C. A. Stidston.

Harvey Prize.

H. E. Quick, A. W. G. Woodforde, equal.
P. L. Giuseppi, certificate.

Appointments.

ADAMS, E. B. D., M.R.C.S., L.R.C.P., appointed Medical Officer to the British Central African Protectorate Company.

* * *

BREWER, A. H., jun., M.R.C.S., L.R.C.P., appointed Honorary Anæsthetist to the German Hospital.

* * *

CALVERLEY, ERNEST J. G., C.M.G., M.D.(Lond.), appointed Assistant Anæsthetist and Pathologist to the Victoria Hospital, Folkestone.

* * *

ELLIS, F. H., M.R.C.S., L.R.C.P., appointed House Surgeon to the Seamen's Hospital ("Dreadnought"), Greenwich.

* * *

GASK, G. E., appointed Assistant Surgeon to City of London Truss Society.

* * *

GOULD, H. N., B.A.(Cantab.), M.R.C.S., L.R.C.P., appointed Junior House Surgeon to the Gloucester Infirmary and Eye Institution.

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HARVEY, F., M.R.C.S., L.R.C.P., appointed Junior Medical Officer to the Seamen's Hospital ("Dreadnought"), Greenwich.

New Addresses.

BRIDGES, E. C., 2, Courtfield Road, South Kensington.

CORNISH, C. V., Ludgershall, Wiltshire.

GASK, G. E., 45, Weymouth Street, W.

GILLESPIE, T., Forest Lodge, Shirley, Southampton.

HILL, CROFT, 101, Earl's Court Road, Kensington, W. (Telephone: 123 Kensington.)

HOBBS, G. C., Burke House, Beaconsfield.

MAITLAND, C. R., 25, Croxted Road, West Dulwich, S.E.

Marriage.

SLOANE—MARSTON.—On the 24th inst., at St. Michael's Church, Coventry, by the Ven. the Archdeacon of Leicester, John Stretton Sloane, M.S., F.R.C.S., eldest son of the late Dr. Sloane, of Leicester, to Emily Hilda, youngest daughter of the late George Marston, of Enderby, Leicester.